PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

HEALTH CARE COMPLAINT FORM

MIKE FISHER
ATTORNEY GENERAL

www.attorneygeneral.gov

Bureau of Consumer Protection
Health Care Unit
14th Floor, Strawberry Square
Harrisburg, PA 17120
(717) 705-6938
Fax: (717) 787-1190

Office Use Only Investigator: Code 1 Code 2 Code 3
Complaint #

YOUR NAME

ADDRESS

CITY STATE ZIP CODE COUNTY

HOME PHONE NUMBER BEST NUMBER TO CALL DURING THE DAY

NAME OF PRIMARY BUSINESS COMPLAINT IS AGAINST PHONE

NAME OF INDIVIDUAL(S) TO WHOM YOU COMPLAINED

ADDRESS

CITY STATE ZIP CODE COUNTY

Type of Insurance: ☐ Indemnity ☐ HMO ☐ PPO ☐ POS ☐ Traditional Medicare/Medical Assistance
☐ Other _____

Provider Information

Physician Name _____
Physician Address _____
Physician Phone _____
Hospital/Facility _____
Physician Name _____
Hospital Address _____
Hospital Phone _____

Health Insurance Information

Insurer _____
Insurer Phone _____
Policy No. _____
Group No. _____
Subscriber's Name _____
Patient's Name _____
Patient's Date of Birth _____
Patient's Relationship to Subscriber _____

FILING A COMPLAINT WITH THE OFFICE OF ATTORNEY GENERAL DOES NOT PRESERVE YOUR APPEAL RIGHTS PURSUANT TO YOUR INSURANCE CONTRACT OR ANY APPLICABLE LAWS (I.E. ACT 68.) TO PRESERVE YOUR RIGHTS YOU MUST FILE AN APPEAL (COMPLAINT OR GRIEVANCE) DIRECTLY WITH YOUR HEALTH INSURER/ ADMINISTRATOR IN CONFORMANCE WITH THE TERMS OF YOUR COVERAGE.

If applicable, please provide information on the last appeal you filed.

Level of appeal _____ Date _____ Outcome _____

To what other agencies have you complained? _____

What action was taken? _____

Have you retained an attorney? ☐ Yes ☐ No If yes, please provide your attorney's name, address and telephone number.

_____

Have you filed a court action? ☐ Yes ☐ No If yes, please state When: _____ Where: _____

IMPORTANT! PLEASE READ AND SIGN ATTACHED MEDICAL RELEASE/AUTHORIZATION

Your Age:
- ☐ 18-29
- ☐ 30-44
- ☐ 45-59
- ☐ 60 or older

How did you find out about us:
- ☐ Visited Office
- ☐ Attended County/ Senior Fair or Speaking Engagement
- ☐ State Legislator/ Agency
- ☐ News Story
- ☐ Internet
- ☐ Other- Please Specify:

_____

_____

(This information will be used for Statistical & Enforcement Purposes Only)

1-877-888-4877

PLEASE COMPLETE THE REVERSE SIDE OF THE COMPLAINT FORM

Please explain your complaint. You may use additional sheets, if necessary. Please write or type clearly. Try to be brief, but be sure to tell **WHAT** happened, **WHEN** it happened, and **WHERE** it happened. Be specific about any oral statements the business made to you, including , if possible, the names of individuals you allege to have made the statements. Describe events in the order in which they happened. Attach **COPIES** of all applicable insurance contracts or policies, medical bills, explanations of benefits, correspondence, receipts, canceled checks (front & back), advertisements or any other papers that relate to your complaint. Please be certain that the copies are **legible** and **labeled**. In addition, please be sure to sign and date the attached **"Authorization to Release Medical/Insurance Records."** We will be unable to pursue your complaint if you neglect to sign and date the "Authorization." Your compliance with the above instructions will greatly facilitate the handling of your complaint. (Use additional pages, if needed.)

What specific resolution are you seeking in order to settle your complaint?

PLEASE READ CAREFULLY

The Attorney General cannot act as your private attorney. As a law enforcement agency, the primary function of the Office of Attorney General's Bureau of Consumer Protection is to represent the public at large by enforcing laws prohibiting fraudulent, deceptive, confusing or misleading trade practices. Through the Bureau of Consumer Protection, Health Care Unit (HCU), the Attorney General does provide a service to consumers through his mediation unit, to resolve individual consumer complaints. The information you provide in this form will be used in an attempt to resolve your complaint and will be shared with the party(ies) against which the complaint is filed. Your complaint will remain on file with our Office and the information contained in it may be used to establish violations of Pennsylvania law.

By signing below:

1. I certify that the information provided in this complaint form, including my identity and any factual statements or allegations, are true and correct to the best of my knowledge, information and belief.

2. I understand that filing a complaint with the HCU does not preserve my appeal rights pursuant to Act 68, Medicare, or my insurance contract or policy.

3. I authorize the HCU to provide a copy of this complaint to any person or company about which I am complaining; and to any person or provider possessing medical and insurance records or information related to the complaint.

4. I authorize the HCU to transfer my complaint to another federal, state, local, or other agency which may have jurisdiction over this matter. This authorization extends to any or all attachments which may be part of my case file, including any medical records the Office may obtain pursuant to my medical release.

YOUR SIGNATURE

DATE

Authorization to Release Medical and Insurance Records

I hereby authorize any of the following: physician or medical practitioner; hospital or medical clinic or facility; insurance company; third party administrator; employer; debt collector; pharmacy; or other provider or person possessing any of the medical and insurance records for

_____
(individual's name, printed), to release the records and information, as described below, to:

Office of Attorney General
Bureau of Consumer Protection, Health Care Unit
14th Floor, Strawberry Square, Harrisburg, Pennsylvania 17120
717.705.6938

These records should relate to the complaint I, or my authorized representative, filed with the Office of Attorney General. The purpose of this authorization is to aid the Health Care Unit in the investigation of my complaint**.**

I authorize the Office of Attorney General, Bureau of Consumer Protection, Health Care Unit, to disclose any information obtained pursuant to this Authorization, along with the other information contained in its case file, to such other federal, state, local or other agencies as deemed appropriate.

I understand that: (1) I have the right, upon written notification to the Office of Attorney General, to revoke this authorization; (2) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign such authorization; and (3) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of Attorney General and will no longer be protected by HIPAA.

This authorization expires upon the conclusion of the investigation into the complaint by the Office of Attorney General.

Signature of Individual or
Authorized Personal Representative _____

Description of Personal Representative's Authority _____

Individual's Social Security Number _____

Individual's Date of Birth _____

Date of Authorization _____

Authorization to Release Medical and Insurance Records Related to Substance Abuse

I hereby authorize the following:

_____ *(physician or medical practitioner);*
_____ *(hospital or other clinical facility);*
_____ *(insurance company);* or

_____ (*third party administrator)*,
possessing medical and insurance records for:

_____ *(individual's name, printed),*
to release the records and information, as described below, to:

Office of Attorney General
Bureau of Consumer Protection, Health Care Unit
14th Floor, Strawberry Square, Harrisburg, Pennsylvania 17120
717.705.6938

These records should relate to substance abuse treatment as identified in the complaint I, or my authorized representative, filed with the Office of Attorney General. The purpose of this authorization is to aid the Health Care Unit in the investigation of my complaint**.**

I authorize the Office of Attorney General, Bureau of Consumer Protection, Health Care Unit, to disclose any information obtained pursuant to this Authorization, along with the other information contained in its case file, to such other federal, state, local or other agencies as deemed appropriate.

I understand that: (1) my substance abuse records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations; (2) I have the right, upon written notification to the Office of Attorney General, to revoke this authorization, except to the extent that action has been taken in reliance upon it; (3) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign such authorization; and (4) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of Attorney General and will no longer be protected by HIPAA.

This authorization expires upon the conclusion of the investigation into the complaint by the Office of Attorney General.

Signature of Individual or
Authorized Personal Representative _____

Description of Personal Representative's Authority _____

Individual's Social Security Number _____

Individual's Date of Birth _____

Date of Authorization _____

PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

MIKE FISHER
ATTORNEY GENERAL

HEALTH CARE COMPLAINT FORM

www.attorneygeneral.gov

WHEN SHOULD YOU FILE A COMPLAINT?

If you are unable to resolve a health-related complaint directly with the person or company you are complaining against, **then** you should file a complaint with the Office of Attorney General, Health Care Unit (HCU), by completing a complaint form and medical release authorization. If your complaint is against your insurance company, then you should refer to your contract to ensure that you have taken all the appropriate steps to file a complaint or grievance directly with the Plan. **Filing a complaint with the HCU does not preserve your appeal rights; therefore, you are encouraged to file an appeal with your insurance company while simultaneously filing a complaint with the HCU.**
The completed forms and any supporting documentation should be mailed to the address below or you may file your complaint online at www.attorneygeneral.gov/ppd/health/form.cfm.

Office of Attorney General
Bureau of Consumer Protection, Health Care Unit
14th Floor, Strawberry Square
Harrisburg, PA 17120

HOW CAN YOU EXPEDITE THE PROCESSING OF YOUR COMPLAINT?

- Complete all portions of the complaint form that apply to your situation
- Describe what actions you have taken to resolve your complaint
- State what action you are seeking in order to resolve your complaint
- Include any supporting documentation that further explains your complaint and your position for resolving the complaint

WHAT SHOULD YOU EXPECT AFTER YOU FILE A COMPLAINT?

Your complaint will be reviewed to determine if the HCU is the most appropriate agency to address your concerns. Upon receipt of your complaint, the HCU will send you an acknowledgment letter:

1. Providing your file number and assigned Agent; or
2. Advising that your complaint has been forwarded to another state or federal agency for handling.

If your complaint is assigned to an Agent, then your Agent will forward a copy of your complaint (as submitted) to the person or company you are complaining against and request a response to the complaint within 15 business days. Your Agent will forward you a copy of the response to your complaint and will keep you informed of any new developments in your case. Please allow your Agent a minimum of 30 days to contact you with an update on your file.